MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (940)

CERTIFICATE OF DEATH

Reg. Dist. No. 9910 92

1. PLACE OF DEATH:
County: Cecil
City or town: Elkton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 days
Hospital, institution, or street address where death occurred: Union Hospital
How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Cecil
City or town: Elkton R D 4
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: not a Veteran

3.(a) FULL NAME: Sarah Eva Ayers

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Widow

6.(b) Name of husband or wife: John W Ayers
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 22 1881

8. AGE: Years 65 | Months 7 | Days 8 | If less than one day ..... hrs. ..... min.

9. Birthplace: Elkton Rural Md
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: Barthlemew Hargan
13. Birthplace: Md

MOTHER
14. Maiden name: Sarah Ann Hall
15. Birthplace: Penna

18. Informant: Mrs Ethel Booth
Address: Elkton R D 4 Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 2 46 (month) (day) (year)
Cemetery or crematory: Bay View, Methodist
Location: Bay View, Md

18. Funeral director: Joseph R Evans
Address: North East Md

19. Nov 1 1946 (Date rec'd by registrar) F R Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 30th 1946 at 10 45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 27 1946, to Oct 30 1946
and that I last saw h alive on Oct 30th 1946

Immediate cause of death	DURATION
a Cerebral Embolism	
Due to Coronary Disease	
Due to Substernal Hyperchondriasis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: John F Cassmeyer M.D. or other
Address: Elkton Date signed Nov 1 46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09911

Reg. Dist. No. 96

1. PLACE OF DEATH:

County: CECIL

City or town: Veterans Administration Hospital (If outside city or town limits, write RURAL and give nearest town) Perry Point, Maryland

How long in above place of death? 1 yr. 2 mos. 29 days

Hospital, institution, or street address where death occurred: Veterans Administration Hospital Perry Point, Maryland

How long in hospital or institution? 1 yr. 5 mos. 27 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No.: #7 F. Alder Drive (If rural, give LOCATION)

2.(a) If veteran, name war: WW-II

3.(a) FULL NAME: BAKER, Charles R.

3.(b) Social Security Number: Not known

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mrs. Ruth M. Baker

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): May 17, 1906

8. AGE: Years	Months	Days	If less than one day
40	5	13	____ hrs. ____ min.

9. Birthplace: Atlantic City, N.J. (Town, county, and state)

10. Usual occupation: Draftsman- Engineer

11. Industry or business: Glenn L. Martin Aircraft Co. Middle River, Md.

FATHER

12. Name: Mary Baker - deceased

13. Birthplace: Atlantic City, N.J.

MOTHER

14. Maiden name: Fred S. Baker

15. Birthplace: Philadelphia, Pa.

16. Informant: Wife, Mrs. Ruth M. Baker

Address: #7 F. Alder Drive, Baltimore 20, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 3, 1946 (month) (day) (year)

Cemetery or crematory: Pleasantville Cemetery

Location: Pleasantville, N.J.

18. Funeral director: PENNINGTON & SON,

Address: Havre de Grace, Md.

19. Oct 31 1946 (Date rec'd by registrar) Irma E. Dunphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 30 1946, at 9:09 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 31 1945, to Oct. 30 1946 and that I last saw him alive on October 30 1946

Immediate cause of death	DURATION
Neoplasm of brain, protoplasmic astrocytoma of frontal lobe bilaterally	Over 1 yr
Due to	
Due to	
Other conditions: -	

(Include pregnancy within 3 months of death)

Major findings of operation: -

Date of op.

Autopsy results: --

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: -- Date of

Where did injury occur? -- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) --

Means of injury -- Injured at work?

23. SIGNATURE: A. E. Trollinger M. D. or other

A. E. TROLLINGER, M.D., Clinical Director

Address: Veterans Administration Perry Point, Md. Date Signed: 10-31-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-1

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09912

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:
County CECIL
City or town VETERANS ADMINISTRATION, Perry Point, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? ~~16 yr. 4 mo. 15 da.~~
Hospital, Institution, or street address where death occurred:
Veterans Administration, Perry Point, Maryland.
How long in hospital or institution? 16 yr. 4 mo. 15 da.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Pa. County Centre
City or town State College
(If outside city or town limits, write RURAL and give nearest town)
Street No. 237 W. Beaver Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war WW I

3.(a) FULL NAME: BEEMER, Claude Y.

3.(b) Social Security Number: -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Married

6.(b) Name of husband or wife: Mrs. Iva Beemer
6.(c) If alive, give age: Unknown years

7. Birth date of deceased (mo., day, yr.): 5-2-1894

8. AGE: Years	Months	Days	If less than one day
52	5	5	- hrs. - min.

9. Birthplace: William Penn, Pa. (Town, county, and state)
10. Usual occupation: Clerk
11. Industry or business: -

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Hospital Records, Veterans Administration, Perry Point, Md.
Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof 10-8-46 (month) (day) (year)
Cemetery or crematory: Hickory Grove Cemetery
Location: Waverly, Penna.

18. Funeral director: PENNINGTON & SON, Havre de Grace, Md.
Address

19. Oct 8 1946 (Date rec'd by registrar) Irma E. Daugherty Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 7 1946, at 7:00A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 22 1930, to October 7 1946
and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Tuberculosis, pulmonary, chronic, far advanced, active	Over 5 yrs.
Due to	
Due to	
Other conditions: Syphilis of the Central Nervous System, Meningo Encephalitic type (Include pregnancy within 3 months of death)	Over 16 yrs

Major findings of operations: None
Date of op. -
Autopsy results: Not performed
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide - Date of -
Where did injury occur? - (City or town) - (County) - (State)
Injured at home, farm, industry, public place (where?) -
Means of injury - Injured at work? No

23. SIGNATURE: V. J. COVALESKY, M.D. Acting Clinical Director
Address Veterans Administration, Perry Point, Md. Date signed 10-7-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

CERTIFICATE OF DEATH

09913

Reg. Dist. No. 91

1. PLACE OF DEATH:
County: Cecil
City or town: Cecilton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Cecil
City or town: Cecilton
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Irving Burke

3.(b) Social Security Number: 213-09-8110

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Clara B.
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): March 2 1881
8. AGE: Years: 65 Months: Days: If less than one day ..... hrs. ..... min.
9. Birthplace: Md (Town, county, and state)
10. Usual occupation: Lunch Room Clerk
11. Industry or business
FATHER 12. Name: Allyn Burke
FATHER 13. Birthplace: Penna.
MOTHER 14. Maiden name: Annie Hurley
MOTHER 15. Birthplace: Delaware
18. Informant: Clara B. Burke
Address: Cecilton Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 31, 1946 (month) (day) (year)
Cemetery or crematory: Cecilton
Location: Cecilton Md.
18. Funeral director: Edward Fellows
Address: Cecilton Md.
19. Oct 29 1946 (Date rec'd by registrar) Mrs. Rodgers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 28 19 46 at 8 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 19 43 to Oct. 28 19 46
and that I last saw him alive on Oct 28, 19 46

Immediate cause of death — DURATION
1. Arteriosclerosis — 5 years
Heart disease
Due to 2. a. Coronary Thrombosis — 20 min.
Due to
Other conditions: Bronchial Asthma — 3 years

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: Walter H. Lee M.D.
M. D. or other
Address: Middletown, Del. Date signed Oct. 29, 1946

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 09914 92

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Cecil
City or town: Elk Mills, Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 years.
Hospital, institution, or street address where death occurred: Rural
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Cecil
City or town: Elk Mills
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Rural
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Laura Mae Burns

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	Wh	Married

6.(b) Name of husband or wife: Frank Burns
6.(c) If alive, give age: 72 years

7. Birth date of deceased (mo., day, yr.): December 20, 1871

8. AGE: Years	Months	Days	If less than one day
75	10	9	hrs. min.

9. Birthplace: Cecil Co. Md (Town, county, and state)
10. Usual occupation: at Home
11. Industry or business

FATHER
12. Name: William Wesley Dowhower
13. Birthplace: Port Deposit, Md

MOTHER
14. Maiden name: Martha Rebecca Green
15. Birthplace: Cecil Co, Maryland

16. Informant: Walter B. McDaniel
Address: Elk Mills, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 2/46 (month) (day) (year)
Cemetery or crematory: Cherry Hill
Location: Cherry Hill Md

18. Funeral director: H. W. Pippin
Address: Elkton, Md

19. Nov 1 1946 (Date rec'd by registrar) F R Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 29 1946, at 9:15 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Sept 21 1946 to Oct 29 1946 and that I last saw h[illegible] alive on Oct 28 1946

Immediate cause of death	DURATION
Cystic Duct Stricture	3 yrs
Due to: Cerebral Hemorrhage	4 wks
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: James L. Johnson M.D.
M. D. or other
Address: Elkton, Md Date signed: Oct 31 46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09915

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH:
County: Cecil
City or town: Elkton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Union Hospital Elkton Md.
How long in hospital or institution? 1 hour

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Cecil
City or town: Chesapeake City Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Robert Coates

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	Col	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 15, 1946

8. AGE: Years | Months 2 | Days 11 | If less than one day: hrs. min.

9. Birthplace: Elkton Md. (Town, county, and state)

10. Usual occupation: Child

11. Industry or business

FATHER
12. Name: Robert Coates
13. Birthplace: Carlton Md.

MOTHER
14. Maiden name: Lillian A Hemsley
15. Birthplace: Carlton Md.

16. Informant: Lillian A Hemsley
Address: Chesapeake City Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 27 1946 (month) (day) (year)
Cemetery or crematory: Carlton Colored Cemetery
Location: Carlton Md.

18. Funeral director: Edward H Glover
Address: Millington Md.

19. Oct 26 1946 (Date rec'd by registrar) F R Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 26 1946 at 2:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw b..... alive on ..... 19.....

	DURATION
Immediate cause of death: Coma	
Pneumonia	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: W. H. Dodson M.D. Medical Examiner Cecil County
Address: Grang Lane Md. M. D. or other
Date signed: 10-26-46

VS A15 9.45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09916

Reg. Dist. No. 96

1. PLACE OF DEATH:
County CECIL
City or town Veterans' Administration, Perry Point, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 yrs. 3 mos. 2 days
Hospital, Institution, or street address where death occurred:
Veterans Administration, Perry Point, Md.
How long in hospital or institution? 9 yrs. 3 mos. 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Pa. County Alleghany
City or town Pittsburgh
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2535 Durham Ave., Banksville
(If rural, give LOCATION)
2.(a) If veteran, name war WW-I

3.(a) FULL NAME: DEL RE, Louis

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: --

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept. 5, 1892

8. AGE: Years	Months	Days	If less than one day
54	1	3	..... hrs. ..... min.

9. Birthplace: San Marco, Italy
(Town, county, and state)

10. Usual occupation: Barber

11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace: Italy

MOTHER
14. Maiden name: Unknown
15. Birthplace: Italy

16. Informant: Hospital Records, Veterans Administration, Perry Point, Md.
Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof 10-11-46 (month) (day) (year)
Cemetery or crematory: Baltimore National Cemetery
Location: Baltimore, Maryland

18. Funeral director: Pennington & Son
Address: PENNINGTON & SON, Havre de Grace, Md.

19. Oct. 11 1946 (Date rec'd by registrar) Irene E. Daughaday Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 8 1946 at 6:44 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 6 1937 to October 8 1946 and that I last saw him alive on October 8 1946

Immediate cause of death: Tuberculosis, pulmonary, chronic, far advanced, active — DURATION: Over 3 yrs

Due to:

Due to:

Other conditions: Dementia Praecox, Hebephrenic type — DURATION: Over 10 yrs
(Include pregnancy within 3 months of death)

Major findings of operations: None — Date of op. --

Autopsy results: Not performed

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of —
Where did injury occur? -- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) --
Means of injury -- Injured at work?

23. SIGNATURE: A. E. Trollinger, M.D. (or other)
Address: Veterans Administration, Perry Point, Md. Date signed 10-11-46

Director

VS A15 9-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for the change of date of birth is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (142)

09917

FILE No. I 0 8 NOV 27 1946

CERTIFICATE OF DEATH

Reg. Diat. No. 92

1. PLACE OF DEATH:
County: Cecil
City or town: Elkton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 hours.
Hospital, institution, or street address where death occurred:
Union Hospital
How long in hospital or institution? 5 hours.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Cecil
City or town: Colora
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Mary Martha Dixon.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	married

6.(b) Name of husband or wife: Francis Dixon.
6.(c) If alive, give age: 23 years

7. Birth date of deceased (mo., day, yr.): Nov. 5 1922

8. AGE: Years	Months	Days	If less than one day
23	11	1	hrs. min.

9. Birthplace: Port Deposit, Md. B. W. D.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Edson Burtains
13. Birthplace: Harford Co. Md.

MOTHER
14. Maiden name: Mary Etta Carney.
15. Birthplace: Harford Co. Md.

16. Informant: Mr. Francis Dixon
Address: Colora, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 9 1946 (month) (day) (year)
Cemetery or crematory: West Cattingham
Location: Colora, Md.

18. Funeral director: J. E. Tyson
Address: Rising Sun Md.

19. Oct 8 1946 (Date rec'd by registrar) F. K. Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 6 1946, at 2250 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10-6 1946, to 10-6 1946
and that I last saw h alive on 19

Immediate cause of death	DURATION
Cerebral Thrombosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury. Injured at work?

23. SIGNATURE: R. L. Dodson M.D. M. D. or other
Address: Rising Sun Md. Date signed: 10-7-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. If correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-1

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (830)

CERTIFICATE OF DEATH

09918 Reg. Dist. No. 96

1. PLACE OF DEATH:
Veterans Administration, Perry Point, Md.
County: CECIL
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 mo. 6 days
Hospital, institution, or street address where death occurred:
Veterans Administration Hospital, Perry Point, Maryland
How long in hospital or institution? Sept. 3, 1946

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Pikesville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2 Pikesville Road
(If rural, give LOCATION)
2.(a) If veteran, name war: WW-I

3.(a) FULL NAME: DUFFY, W. Clinton

3.(b) Social Security Number: 179-07-5312

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	Married

6.(b) Name of husband or wife: Coretta S. Bayline
6.(c) If alive, give age: 52 years

7. Birth date of deceased (mo., day, yr.): Dec. 4, 1887

8. AGE:

Years	Months	Days	If less than one day
58	10	19	....hrs. ....min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation: Draftsman and Estimator

11. Industry or business

FATHER
12. Name: John J. Duffy, deceased
13. Birthplace: Baltimore County

MOTHER
14. Maiden name: Amanda R. Seddicum, deceased
15. Birthplace: Baltimore County

16. Informant: Wife, Mrs. Coretta S. Duffy
Address: 2 Pikesville Road, Pikesville 8, Maryland

17. Removal (Burial, cremation, or removal, Which?) Date thereof Oct. 23, 1946 (month) (day) (year)
Cemetery or crematory: Cathedral Cemetery
Location: Baltimore, Maryland

18. Funeral director: H. W. Mearsson
H. W. MEARS & SON
Address: 805 N. Calvert Street, Baltimore, Md.

19. Oct. 23 1946 (Date rec'd by registrar) Irene E. Daugherty Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 23 1946, at 7:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 17 1946, to Oct. 23 1946 and that I last saw him alive on October 23 1946

Immediate cause of death	DURATION
Cerebral hemorrhage	2 weeks
Due to	
Due to	
Other conditions: Cerebral arteriosclerosis	4 months

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op. —
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of —
Where did injury occur? — (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work?

23. SIGNATURE: V. J. COVALESKY, M.D., Acting Clin. Director
M.D., or other
Address: Veterans' Administration, Perry Point, Md. Date signed: 10-23-46

VS A15 9-45-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-a)

CERTIFICATE OF DEATH

★ 09919

Reg. Dist. No. 92

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH: Cecil

County

City or town Elkton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Half a day

Hospital, institution, or street address where death occurred:

Union Hospital

How long in hospital or institution? ½ day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Cecil

City or town Elkton - R.D. 3

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Elizabeth J. Goff

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Widow

6.(b) Name of husband or wife Joseph Goff

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 4 - 1870

8. AGE: Years	Months	Days	If less than one day
76	5	22	..... hrs. ..... min.

9. Birthplace New Hampshire (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Wm Ewing

13. Birthplace New Hampshire

MOTHER 14. Maiden name No Information

15. Birthplace

16. Informant James Lowry

Address Elkton R.D. 3. Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 29 (month) 46 (day) (year)

Cemetery or crematory Cherry Hill. M.E.

Location Cherry Hill Md

18. Funeral director H.W. Pippin

Address Elkton. Md

19. Oct 29 19 46 (Date rec'd by registrar) F.K. Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 26 19 46, at 5.55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 26 - 19 46, to Oct 26 19 46

and that I last saw h[illegible] alive on Oct 26 19 46

Immediate cause of death	DURATION
Cerebral Thrombosis	about 6 weeks
Due to General arterio sclerosis	unknown
Due to Cardio-Vascular Renal Disease	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE G. H. McKnight, M.D. M. D. or other

Address Elkton Md Date signed 10/27/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

CERTIFICATE OF DEATH

★ 09920

Reg. Diat. No. 96

M

I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Cecil

City or town: Perryville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 42 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Cecil

City or town: Perryville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Caroline H. Shipley Gorrell

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Willis B. Gorrell

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 29, 1873

8. AGE: Years	Months	Days	If less than one day
73	5	27	hrs. min.

9. Birthplace: Pikesville, Balto. Co., Md. (Town, county, and state)

10. Usual occupation: House wife

11. Industry or business

FATHER 12. Name: John Shipley

13. Birthplace: Balto. Co., Md.

MOTHER 14. Maiden name: Emma Bowen

15. Birthplace: Baltimore Co., Md.

16. Informant: Willis B. Gorrell

Address: Perryville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 29, 1946 (month) (day) (year)

Cemetery or crematory: Asbury

Location: Rural, Port Deposit, Md.

18. Funeral director: Vega Catterson & Son

Address: Perryville, Md.

19. Oct 29 1946 (Date rec'd by registrar) Irene E. Daugherty Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 26 1946, at 6.45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 16 1945 to October 26 1946 and that I last saw h.. alive on October 25 1946

	DURATION
Immediate cause of death: Carcinoma of liver	6 mo
Due to: Metastasis from Carcinoma of Breast (removed)	18 mo
Due to:	
Other conditions: Dilated Heart	6 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: Carcinoma of Breast Date of op. Aug 15 1945

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J. F. Magraw M. D. or other

Address: Perryville Md. Date signed: 10/28/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (137-a)

CERTIFICATE OF DEATH

09921

Reg. Diat. No. 92

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Cecil Co.

City or town: Elkton Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 days

Hospital, institution, or street address where death occurred: Union Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Cecil Co.

City or town: Rising Sun Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Samuel R. Haines

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Addie Haines

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec 13 1872

8. AGE: Years	Months	Days	If less than one day
73	10	18	..... hrs. ..... min.

9. Birthplace: Rising Sun Md. (Town, county, and state)

10. Usual occupation: Retired

11. Industry or business

FATHER — 12. Name: Jefferson Haines

FATHER — 13. Birthplace: Md.

MOTHER — 14. Maiden name: Unknown

MOTHER — 15. Birthplace: Unknown

16. Informant: Frank Haines

Address: 67 South Walnut St

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 3 1946 (month) (day) (year)

Cemetery or crematory: Bainbridge Md.

Location: Rising Sun Md.

18. Funeral director: J. E. Tyson

Address: Rising Sun Md.

19. Nov 1 1946 (Date rec'd by registrar) H R Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 31 1946 at 6:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10-20 1946, to 10-31 1946

and that I last saw h... alive on 10/30 1946

Immediate cause of death	DURATION
Bronchial Asthma	
Bronchopneumonia	
Due to: Pneumonia	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Bronchoscopy Prostatectomy

Hypertrophied Date of op. 10-28-46

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: H. C. Cantwell M.D. M. D. or other

Address: Conte Cant Md. Date signed: Nov 1/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (55-2)

CERTIFICATE OF DEATH

09922

Reg. Dist. No. 96

1. PLACE OF DEATH:

County: Cecil

City or town: Perryville, Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Cecil

City or town: Perryville, Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Edward A. Jackson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Hannah Jackson

6.(c) If alive, give age: 70 years

7. Birth date of deceased (mo., day, yr.): Nov. 3, 1875

8. AGE: Years	Months	Days	If less than one day
70	11	17	..... hrs. ..... min.

9. Birthplace: Blythedale, Cecil, Md. (Town, county, and state)

10. Usual occupation: Farmer Retired

11. Industry or business

FATHER — 12. Name: Unknown

13. Birthplace

MOTHER — 14. Maiden name: Caroline Jackson

15. Birthplace: Blythedale, Md

16. Informant: Hannah Jackson

Address: Perryville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 23, 1946 (month) (day) (year)

Cemetery or crematory: Asbury

Location: Port Deposit, Md. Rural

18. Funeral director: Lee A. Patterson & Son

Address: Perryville, Md.

19. Oct. 23 '46 (Date rec'd by registrar) Irene E. Daugherty Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 20 1946, at 8.45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 19 42, to Oct 20 1946 - and that I last saw h[illegible] alive on Oct. 20 - 1946

Immediate cause of death	DURATION
Neurg. Sarcoma of Chest.	4½ yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: E. J. Benson, M.D. M. D. or other

Address: Port Deposit Md Date signed: 10/22/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15


RECEIVED
OCT 25 1946
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (144)

CERTIFICATE OF DEATH

★ 10453

Reg. Diat. No. 940

1. PLACE OF DEATH:
County: Cecil
City or town: North East Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution? PTRE

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Cecil
City or town: North East Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Payne Maritta Ketola

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	White	Married

6.(b) Name of husband or wife: Edwin F. Ketola
6.(c) If alive, give age: x28 years

7. Birth date of deceased (mo., day, yr.): October 22 1918

8. AGE: Years: 28 Months: Days: 9 If less than one day: hrs. min.

9. Birthplace: Finland
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

MOTHER FATHER
12. Name: Gunnar Nelmimen
13. Birthplace: Finland.
MOTHER
14. Maiden name: Ingrid Lingren
15. Birthplace: Finland

16. Informant: Gunnar Nelmimen
Address: North East Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 4 1946 (month) (day) (year)

Cemetery or crematory: Cemetery
Location: North East Methodist
18. Funeral director: Joseph R. Grant
Address: North East, Md.

19. 11-6 1946 Lida V. Owens
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 31 1946 at 3:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Gunshot of left side of head.	
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Suicide Date of 10-31-46
Where did injury occur? North East (City or town) Cecil (County) Md. (State)
Injured at home, farm, industry, public place (where?) Home
Means of injury: 16 Gauge Shot Gun. Injured at work?

23. SIGNATURE: R. L. Dodson M.D. Medical Examiner for Cecil County
M. D. or other
Address: Rising Sun Md. Date signed 11-1-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45 M

1-3

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23)

09923

CERTIFICATE OF DEATH

Reg. Diat. No. 92

1. PLACE OF DEATH:
County: New Castle
City or town: Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life time.
Hospital, institution, or street address where death occurred: Newark Del
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Cecil
City or town: Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Newark Del
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: William Cannon Klink

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife: Ida L. Klink 6.(c) If alive, give age: 65 years
7. Birth date of deceased (mo., day, yr.): June - 1884

8. AGE: Years	Months	Days	If less than one day
62	4	11	..... hrs. ..... min.

9. Birthplace: Phila. Pa (Town, county, and state)
10. Usual occupation: Clerk
11. Industry or business: Fibre

FATHER
12. Name: Clarence C. Klink
13. Birthplace: Douglasville Pa

MOTHER
14. Maiden name: Ada E. Cannon
15. Birthplace: Cambridge Indiana

16. Informant: Mrs Ida L. Klink
Address: Newark R. D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 21 46 (month) (day) (year)
Cemetery or crematory: Rolling Green Memorial Park Pa
Location: Near Harrisburg Pa
18. Funeral director: R. T. Jones
Address: Newark Del

19. Oct 18 1946 (Date rec'd by registrar) F R Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 16 1946 at 5:40 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 5 1946, to Oct 16 1946
and that I last saw him alive on Oct 16 1946

	DURATION
Immediate cause of death: Myocardial Infarction	
Due to: Coronary Thrombosis	6 months
Due to:	
Other conditions: none	

(Include pregnancy within 3 months of death)
Major findings of operations: none
Date of op.:
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: E Hughes Sutton M.D.
M. D. or other
Address: Newark, Del Date signed: 10-17-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Klein.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (8-d)

09924

CERTIFICATE OF DEATH

Reg. Diat. No. 96

1. PLACE OF DEATH:
County CECIL
City or town Veterans Administration, Perry Point, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yrs. 9 mos. 7 days
Hospital, Institution, or street address where death occurred:
Veterans Administration, Perry Point, Md.
How long in hospital or institution? 2 yrs. 9 mos. 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3407 Keene Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war WW-I

3.(a) FULL NAME LAUBER, Henry L.

3.(b) Social Security Number Unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	Single

6.(b) Name of husband or wife --
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) August 16, 1888

8. AGE: Years	Months	Days	If less than one day
58	2	10	..... hrs. ..... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual occupation Groceryman
11. Industry or business
FATHER 12. Name Unknown - deceased
13. Birthplace Unknown
MOTHER 14. Maiden name Unknown - deceased
15. Birthplace Unknown
16. Informant Hospital records - Veterans Administration Hospital
Address Perry Point, Maryland
17. Removal (Burial, cremation, or removal. Which?) Date thereof Oct. 29, 1946 (month) (day) (year)
Cemetery or crematory Baltimore National Cemetery
Location Baltimore, Maryland
18. Funeral director Pennington & Son
Address PENNINGTON & SON Havre de Grace, Md.
19. Oct. 29 1946 (Date rec'd by registrar) Irene E. Daugherty Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 26 1946 at 1:18 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 19, 1944 to October 26 1946 and that I last saw him alive on October 26 1946

Immediate cause of death	DURATION
Bronchopneumonia	6 days
Due to	
Due to	
Other conditions Arterial hypertension; Cerebral arteriosclerosis; left hemiplegia	Prior to admission this hospital

(Include pregnancy within 3 months of death)
Major findings of operations --
Date of op. --
Autopsy results --
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide -- Date of .....
Where did injury occur? -- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) --
Means of injury -- Injured at work?

23. SIGNATURE A. E. Trollinger
A. E. TROLLINGER, M.D., Clinical Dir. M.D. or other
Address Veterans Administration Hospital, Perry Point, Maryland Date Signed 10-28-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (57-E)

CERTIFICATE OF DEATH

Reg. Dist. No. 09925 42

1. PLACE OF DEATH:
County: Cecil
City or town: Elkton (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 days
Hospital, institution, or street address where death occurred: Union Hospital
How long in hospital or institution? 3 da

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Md County: Cecil
City or town: Elkton (If outside city or town limits, write RURAL and give nearest town)
Street No. 307 Hollingsworth Manor (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME Baby Girl Lawson
Donna Lee ~~Baby~~ ~~Boy~~

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Wh.	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) Oct 21, 1946

8. AGE:

Years	Months	Days	If less than one day
		3	hrs. min.

9. Birthplace: Elkton, Md (Town, county, and state)
10. Usual occupation:
11. Industry or business:
FATHER 12. Name: Norman Lawson
13. Birthplace: Baltimore Co., Md
MOTHER 14. Maiden name: Gertrude Wyatt
15. Birthplace: Dover, Del.
16. Informant: Norman Lawson
Address: 307 Hollingsworth Manor Elkton, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 26/46 (month) (day) (year)
Cemetery or crematory: Mt Olivet
Location: Kent Co. Md
18. Funeral director: H. W. Poppino
Address: Elkton, Md
19. Oct 25 1946 (Date rec'd by registrar) F R Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 24 1946 at 8 a. m.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 21 1946, to Oct 24 1946
and that I last saw h. alive on Oct. 23 1946.

Immediate cause of death	DURATION
Congenital - deformity -	
Spina - bifida -	
Due to: + Cleft palate	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

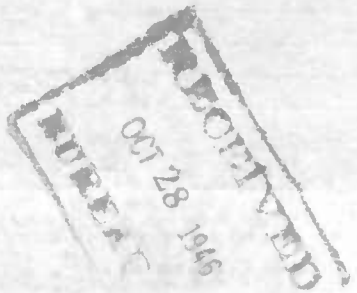
22. VIOLENCE: If death was due to exteroal causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Mildred H. Sprecher M. D.
M. D. or other
Address: Elkton, Md Date signed: Oct 25, 1946

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15


RECEIVED
OCT 28 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

95-e

★ 09926 92

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

1. PLACE OF DEATH:
County: Cecil
City or town: Michaux Valley
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Cecil
City or town: North East Rural.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If roral, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Wm. C McCreary

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widow

6.(b) Name of husband or wife: Sarah Jane McCreary
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct 24 1867

8. AGE: Years: 79 | Months: — | Days: 2 | If less than one day: hrs. min.

9. Birthplace: Wilkesborough N. C
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: Farmer

FATHER
12. Name: Frank McCreary
13. Birthplace: North Carolina

MOTHER
14. Maiden name: Mary Chubs
15. Birthplace: N. C

16. Informant: Harry F. McCreary
Address: North East Rd

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 31-46 (month) (day) (year)
Cemetery or crematory: Union
Location: Elkton R.D. 5 Md

18. Funeral director: Joseph R. Grason
Address: North East Md

19. Oct 29 19 46 (Date rec'd by registrar) J R Grason Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 26 19 46, at 12 05 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Cardiac Failure	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: R E Dodson M.D. Medical Examiner for Cecil County
Address: Rising Sun Md M. D. or other
Date signed 10-29-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (164a)

CERTIFICATE OF DEATH

★ 09927

Reg. Diat. No. 940

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Cecil
City or town: Bayview North East
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 years.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Cecil
City or town: North East Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME William T. Montgomery. **3.(b) Social Security Number**

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	White	Widower.

6.(b) Name of husband or wife: Catherine Montgomery
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec-10 1859

8. AGE:

Years	Months	Days	If less than one day
86	10	21	hrs. min.

9. Birthplace: Delaware (Town, county, and state)
10. Usual occupation: Retired Farmer.
11. Industry or business

FATHER
12. Name: Evan T Montgomery
13. Birthplace: Delaware.

MOTHER
14. Maiden name: Mary B Groves.
15. Birthplace: Delaware.

16. Informant: Mrs. Jones Armour
Address: North East, Md RD 2

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 3 1946 (month) (day) (year)
Cemetery or crematory: Cem Iem
Location: Hopewell,
18. Funeral director: Joseph R. Grant
Address: North East, Md.

19. 11-6 1946 (Date rec'd by registrar) Lida V Owens Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 31 1946, at 11P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

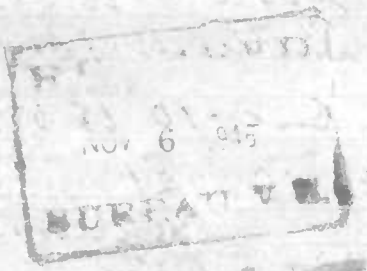
Immediate cause of death	DURATION
Strangulation	
Due to A Hanging	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Suicide Date of 10-31-46
Where did injury occur? Bayview (City or town) Cecil (County) Md. (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: R LeDodson MD Medical Examiner Cecil County
Address: Rising Sun Md. M. D. or other
Date signed: 11-1-46


NOV 6 945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09928

Reg. Dist. No. 96

1. PLACE OF DEATH:
County: Cecil
City or town: Veterans Administration, Perry Point, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 yrs. 8 mos. 6 days
Hospital, institution, or street address where death occurred:
Veterans Administration, Perry Point, Md.
How long in hospital or institution? 10yrs. 8 mos. 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: ~~Baltimore~~
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2813 Montebello Terrace
(If rural, give LOCATION)
2.(a) If veteran, name war: WW-I ✓

3.(a) FULL NAME: NAGORNOWSKI, Henry P.

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

B.(b) Name of ~~husband~~ wife: Mamie Nagornowski
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 13, 1889

8. AGE: Years	Months	Days	If less than one day
57	3	6	..... hrs. ..... min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)
10. Usual occupation: Tailor and hotel valet
11. Industry or business

FATHER
12. Name: Name unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown - deceased
15. Birthplace: Unknown

16. Informant: Hospital records
Address: Veterans' Administration, Perry Point, Maryland

17. Removal (Burial, cremation, or removal. Which?) Date thereof Oct. 19, 1946 (month) (day) (year)
Cemetery or crematory: National Cem.
Location: Baltimore, Md.
18. Funeral director: Ruck Funeral Home
Address: 5305 Harford Rd., Baltimore, Md.
19. Oct 19 1946 (Date rec'd by registrar) Irene E. Danghart Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 19 1946 at 6:00 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 13, 1936 to Oct. 19 1946 and that I last saw him alive on October 19 1946

Immediate cause of death	DURATION
General paresis, tabetic type	Over 10 yrs
Due to	
Due to	
Other conditions: Rheumatic heart disease	
Cerebral hemorrhage, secondary to General paralysis	

(Include pregnancy within 3 months of death)

Major findings of operation: —
Date of op. —
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: —— Date of ——
Where did injury occur? ——
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ——
Means of injury —— Injured at work?

23. SIGNATURE: A.E. Trollinger
A.E. TROLLINGER, M.D., Clin. Director
(M.D. or other)
Address: Veterans Administration, Perry Point, Md. Date signed 10-19-46

VS A15 9-45-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23d)

CERTIFICATE OF DEATH

★ 09929

Reg. Diat. No. 96

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9.45

1. PLACE OF DEATH:

County: Cecil

City or town: Port Deposit Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Stanley Nursing Home

How long in hospital or institution? 2 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Cecil

City or town: Chesapeake City

(If outside city or town limits, write RURAL and give nearest town)

Street No. —

(If rural, give LOCATION)

2.(a) If veteran, name war: was a Veteran

3.(a) FULL NAME William F Pensel

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 2 1866

8. AGE: Years 80 | Months 5 | Days 18 | If less than one day: hrs. min.

9. Birthplace: Chesapeake City, Cecil, Md (Town, county, and state)

10. Usual occupation: Butcher

11. Industry or business: —

FATHER 12. Name: Jacob Pensel

13. Birthplace: Germany

MOTHER 14. Maiden name: Mary Shuck

15. Birthplace: Germany

16. Informant: Harry Pensel

Address: Chesapeake City Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 22-46 (month) (day) (year)

Cemetery or crematory: Bethel

Location: Chesapeake City Md

18. Funeral director: Joseph R Leary

Address: North East Md

19 Oct 21 19 46 Irene E Daugherty (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 20 1946, at 5:00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 15 1946 to Oct 19 1946

and that I last saw him alive on Oct-19- 1946

Immediate cause of death	DURATION
Chronic Myocarditis	10 yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: C J Benson M D

M. D. or other

Address: Port Deposit Md Date signed 10/21/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-C)

CERTIFICATE OF DEATH

★ 09930

Reg. Dist. No. 92

1. PLACE OF DEATH:
County Cecil
City or town Fairhill
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Route 213
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Cecil
City or town Elkton Md Hollingsworth Manor 126
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war World War 2

3.(a) FULL NAME alfred J Rigler

3.(b) Social Security Number 221-14-2950

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	White	Married

6.(b) Name of husband or wife Louise Rigler
6.(c) If alive, give age 22 years

7. Birth date of deceased (mo., day, yr.) Dec 19 1921

8. AGE:

Years	Months	Days	If less than one day
24	10	7	...hrs. ...min.

9. Birthplace Landenburg Pa (Town, county, and state)
10. Usual occupation Carpenter
11. Industry or business
FATHER 12. Name William Rigler
13. Birthplace Landenburg Pa
MOTHER 14. Maiden name Lydia Crosdale
15. Birthplace Landenburg Pa
16. Informant Louise Rigler
Address 126 Hollingsworth Manor Elkton Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 29 1946 (month) (day) (year)
Cemetery or crematory St Patricks Cemetery
Location Kennett Square Pa
18. Funeral director H W Pippin
Address Elkton Maryland
19. Oct 28 1946 (Date rec'd by registrar) F R Frazer (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 26 1946, at 1255 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ...19..., to ...19...
and that I last saw h... alive on ...19...

Immediate cause of death	DURATION
Coronary Thrombosis	
Due to Arteriosclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of 10/26-46
Where did injury occur? Fairhill Cecil Md (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Highway
Means of injury Struck Overturned Injured at work? yes

23. SIGNATURE R L Dodson MD Medical Examiner Cecil County
Address Rising Sun Md M. D. or other
Date signed 10-26-46

VS A15 9.45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09931

Reg. Dist. No. 96

1. PLACE OF DEATH:
County: Cecil
City or town: Veterans Administration, Perry Point, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yrs. 2 mos. 26 days
Hospital, institution, or street address where death occurred:
Veterans Administration, Perry Point, Md.
How long in hospital or institution? 2 yrs. 2 mos. 26 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: W. Va. County: Hancock
City or town: Weirton
(If outside city or town limits, write RURAL and give nearest town)
Street No. 302 Avenue H
(If rural, give LOCATION)
2.(a) If veteran, name war: WW-I

3.(a) FULL NAME: RILEY, Elmer J.

3.(b) Social Security Number: Unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	Married

6.(b) Name of ~~husband~~ or wife: Martha A. Riley
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan. 5, 1896

8. AGE: Years	Months	Days	If less than one day
50	5	16	..... hrs. ..... min.

8. Birthplace: Bessemer, Pa. (Town, county, and state)
10. Usual occupation: Steel mill worker
11. Industry or business: Steel
FATHER 12. Name: Unknown - deceased
FATHER 13. Birthplace: Unknown
MOTHER 14. Maiden name: Mary Nordquist
MOTHER 15. Birthplace: Finland
16. Informant: Hospital records, Veterans' Administration, Perry Point, Md.
Address
17. Removal (Burial, cremation, or removal. Which?) Date thereof: Oct. 19, 1946 (month) (day) (year)
Cemetery or crematory: Paris Cemetery
Location: Paris, Penna.
18. Funeral director: Pennington & Son
PENNINGTON & SON
Address: Havre de Grace, Md.
19. Oct. 19 1946 (Date rec'd by registrar) Irma E. Daughaday (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 17 1946, at 4:15 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 21 1944, to Oct. 17 1946 and that I last saw him alive on October 17 1946

	DURATION
Immediate cause of death: Cerebral hemorrhage	5 hrs.
Due to:	
Due to:	
Other conditions: Psychosis due to syphilis of central nervous system, meningo-encephalitic type (Include pregnancy within 3 months of death)	Over 3 yrs

Major findings of operations: --
Date of op. --
Autopsy results: --
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: -- Date of --
Where did injury occur? -- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) --
Means of injury -- Injured at work? --

23. SIGNATURE: A. E. Trollinger (M.D. or other)
A. E. TROLLINGER, M.D., Clinical Director
Address: Veterans' Administration, Perry Point, Md. Date signed: 10-18-46

VS A15 9-45-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09932

Reg. Dist. No. 940

1. PLACE OF DEATH:
County: Cecil
City or town: North East Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: N. Y. County:
City or town: Brooklyn N.Y.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 245 E 34th St
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME William Romanoff

3.(b) Social Security Number 161-22-4530

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	White	Single

6.(b) Name of husband or wife: Single

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 17, 1928

8. AGE: Years 17 | Months 10 | Days 14 | If less than one day: hrs. min.

9. Birthplace: Scranton Pa. (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER 12. Name: Michael Romanoff

13. Birthplace: Austria

MOTHER 14. Maiden name: Fanny Rulbocki

15. Birthplace: Austria

16. Informant: Copied from Pa Birth Certy

Address: Harrisburg Pa.

17. Burial, cremation, or removal. Which?: Removal Date thereof: Nov 5. 1946 (month) (day) (year)

Cemetery or crematory: Scranton Cemetery

Location: Scranton Pa

18. Funeral director: H. W. Pierpoint

Address: Easton Md

19. Nov 6 1946 (Date rec'd by registrar) Lucia V. Owens Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 31 1946 at 10 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Fractured Skull & Crushed Chest	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of: 10/31-46
Where did injury occur? North East Cecil Md.
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?): Route 40
Means of injury: Auto Turned over Injured at work?

23. SIGNATURE: R. LeDodson M.D. Medical Examiner Cecil County
M. D. or other
Address: Rising Sun Md Date signed: 10/31-46

VS A15 9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09933

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:
County: Cecil
City or town: Bainbridge, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
USN. Hospital Bainbridge, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 607 E. 34th St.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Polly Ann Scott

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	W.	—

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct. 8 1946

8. AGE: Years: Newborn | Months: | Days: | If less than one day: 1 hrs. 30 min.

9. Birthplace: Bainbridge Md. Cecil County
(Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER
12. Name: Robert Charles Scott
13. Birthplace: Pittsburgh, Pa.

MOTHER
14. Maiden name: Dixie Carol Pine
15. Birthplace: Walsenburg Colorado.

18. Informant: U.S. N. Hosp. records
Address:

17. Cremation
(Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)
Cemetery or crematory:
Location:

18. Funeral director: (Cremation at USN Hospital) authorized by parents
Address:

19 Oct. 10 1946 (Date rec'd by registrar) Irene E. Daugherty Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 8 Oct. 1946 at 10:10 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8 Oct 1946 to 8 Oct 1946 and that I last saw her alive on 8 Oct 1946

Immediate cause of death	DURATION
Congenital deformity	1 hr. 30 min
Due to (Microcephalus + craniorachesis)	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: G R Johnston Cdr. (M.C.) USN. M. D. or other
Address: USN T.C. Bainbridge Md. Date signed: 9 Oct 46.

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. Re cremation, see under Burial.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83)

CERTIFICATE OF DEATH

09934

Reg. Diat. No. 92

1. PLACE OF DEATH:

County: Cecil

City or town: Elkton Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 days

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Cecil

City or town: North East

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war.

3.(a) FULL NAME Ralph B Simpers

3.(b) Social Security Number 213-16-1148

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	White	Married

6.(b) Name of husband or wife: Mabel Simpers

6.(c) If alive, give age: 45 years

7. Birth date of deceased (mo., day, yr.): Dec 12 1893

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
52	10	6		

9. Birthplace: North East Md (Town, county, and state)

10. Usual occupation: Crane Operator

11. Industry or business: U. S. Govt

FATHER — 12. Name: Samuel J. Simpers

13. Birthplace: Md

MOTHER — 14. Maiden name: Lola Burnside

15. Birthplace: Md

16. Informant: Mrs Ralph B. Simpers

Address: Md

17. (Burial, cremation, or removal. Which?) Burial — Date thereof: 10 (month) - 30 (day) 46 (year)

Cemetery or crematory: Methodist

Location: North East Md

18. Funeral director: Joseph R Lucas

Address: North East Md

19. (Date rec'd by registrar) Oct 29 1946 — F R Frazier, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 18 1946, at — M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Drowned.	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide? Accident Date of 10-18-46

Where did injury occur? Elkton (City or town) Cecil (County) Md. (State)

Injured at home, farm, industry, public place (where?) Big Elk Creek

Means of injury: Fell Off Culvert Injured at work? no

23. SIGNATURE: R L Dodson MD Medical Examiner for Cecil County (M. D. or other)

Address: Rising Sun Md Date signed: 10/28/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9.45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (91-C)

CERTIFICATE OF DEATH

09935 96
Reg. Diat. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Cecil
City or town: Port Deposit Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? about 15 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Cecil
City or town: Port Deposit, Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Curtis Sims

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Viola Sims
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb. 28, 1964

8. AGE: Years	Months	Days	If less than one day
42	7	16	..... hrs. ..... min.

9. Birthplace: Chester, Chester Co., S. C.
(Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: B. & O. Rail Road
FATHER 12. Name: David Sims
13. Birthplace: Chester Co., S. C.
MOTHER 14. Maiden name: Unknown
15. Birthplace
16. Informant: Viola Sims
Address: Port Deposit, Md. Rural
17. Removal (Burial, cremation, or removal. Which?) Date thereof Oct. 15, 1946 (month) (day) (year)
Cemetery or crematory
Location: Tr. Union, Union Co., S. Carolina
18. Funeral director: Lee A. Patterson & Son
Address: Perryville, Md.
19. Oct 15 1946 Irene E. Danforth
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October - 14 - 1946, at 9.45 A. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 6 - 1946, to Oct - 14 - 1946
and that I last saw him alive on October - 14 - 1946.

Immediate cause of death	DURATION
Acute Bronchitis	3 days
Due to	
Due to	
Other conditions Acute Bronchitis.	8 days.

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: E. P. Benson, M. D.
M. D. or other
Address: Port Deposit Md Date signed 10-14-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23)

CERTIFICATE OF DEATH

09936 (9)

★ Reg. Dist. No. ....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9.45 M

1. PLACE OF DEATH:
County Cecil
City or town Frenchtown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 years.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Va. County Richmond
City or town Richmond
(If outside city or town limits, write RURAL and give nearest town)
Street No. ....
(If rural, give LOCATION)
2.(a) If veteran, name war ....

3. (a) FULL NAME Henry Smith

3. (b) Social Security Number ....

4. Sex M. | 5. Color or race Col. | 6.(a) Single, married, widowed, or divorced Widower

6.(b) Name of ~~husband~~ or wife Laura Smith

6.(c) If alive, give age .... years

7. Birth date of deceased (mo., day, yr.) March 15 1861

8. AGE: Years 85 | Months 6 | Days 21 | If less than one day .... hrs. .... min.

9. Birthplace Richmond Va. (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business ....

FATHER 12. Name unknown.
13. Birthplace ....

MOTHER 14. Maiden name unknown.
15. Birthplace ....

16. Informant Lyons Harris
Address Middletown Del

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 10, 1946 (month) (day) (year)

Cemetery or crematory Cecilton cem.
Location Cecilton Md.

18. Funeral director Austin O. Caulk
Address 822 Pine St. Wilm. Del.

19. Oct 10th 1946 (Date rec'd by registrar) Irving Burbage Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 6 1946, at 12:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from .... 19.... to .... 19....
and that I last saw h.... alive on .... 19....

	DURATION
Immediate cause of death Chronic Myocarditis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations .... Date of op. ....
Autopsy results ....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide .... Date of ....
Where did injury occur? .... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ....
Means of injury .... Injured at work?

23. SIGNATURE P. L. Dodson MD Medical Examiner for Cecil County
Address .... M. D. or other
Date signed 10-6-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

09937

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:
County: Cecil
City or town: Port Deposit
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 73 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Cecil
City or town: Port Deposit
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: William Elmore Stebbing

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mary E.
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept. 26, 1873

8. AGE: Years	Months	Days	If less than one day
73	1	0	..... hrs. ..... min.

9. Birthplace: Port Deposit, Cecil, Md. (Town, county, and state)
10. Usual occupation: Foreman
11. Industry or business: U.S. Veterans Supply Depot
FATHER — 12. Name: George H. Stebbing
13. Birthplace: Cecil Co., Md.
MOTHER — 14. Maiden name: Margaret Whalen
15. Birthplace: Cecil Co., Md.
16. Informant: Mary E. Stebbing
Address: Port Deposit, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 30, 1946 (month) (day) (year)
Cemetery or crematory: Hopewell
Location: Port Deposit, Md., Rural
18. Funeral director: Lee A. Patterson & Son
Address: Perryville, Md.
19. Oct 29 1946 (Date rec'd by registrar) Irene E. Daugherty Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 26 1946, at 11:15 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 25 1946 to Oct 26- 1946 and that I last saw him alive on Oct 26- 1946

Immediate cause of death	DURATION
Arteriosclerosis	10 yrs
Due to	
Due to	
Other conditions: Hypertension	10 yrs

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: E. J. Brown, M.D. M. D. or other
Address: Port Deposit, Md. Date signed 10/28/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

(47) (X) 09938

Reg. Dist. No. 94

1. PLACE OF DEATH:

County: Cecil

City or town: North East

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Cecil

City or town: North East

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war: not a veteran

3.(a) FULL NAME: Paul Sweet

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Anna Agnes Sweet

6.(c) If alive, give age: 57 years

7. Birth date of deceased (mo., day, yr.): Feb 12 1883

8. AGE: Years: 63 | Months: 8 | Days: 9 | If less than one day: ....hrs. ....min.

9. Birthplace: North East Cecil Co. Md (Town, county, and state)

10. Usual occupation: Druggist

11. Industry or business

FATHER — 12. Name: John N. Sweet — 13. Birthplace: N. Y

MOTHER — 14. Maiden name: Humphrey — 15. Birthplace: N. Y

16. Informant: Mrs. Paul Sweet

Address: North East, Md

17. Cremation (Burial, cremation, or removal, which?) Date thereof: Oct 24-1946 (month) (day) (year)

Cemetery or crematory: Silverbrook

Location: Wilmington, Del

18. Funeral director: Joseph R. Grant

Address: North East Md

19. 10-28 1946 (Date rec'd by registrar) Lida V. Owens Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 21 October 1946, at 8:30 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10 Oct 1946 to 21 Oct. 1946 and that I last saw him alive on 21 October 1946

Immediate cause of death: Obstructive jaundice — DURATION: 6 weeks

Due to: Probable Carcinoma of the Liver — 5 years

Due to:

Other conditions: —

(Include pregnancy within 3 months of death)

Major findings of operations: — Date of op. —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Klaus H Thuebner M.D. (M. D. or other)

Address: North East, Maryland Date signed: 21 Oct. '46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

★ 09939

Reg. Dist. No. 92

M

MARGIN RESERVED FOR BINDING

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County: Cecil
City or town: Elkton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 days.
Hospital, institution, or street address where death occurred:
Union Hospital
How long in hospital or institution? 15 da.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Cecil.
City or town: Chesapeake City
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Emma P. Swing.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	Wh	Widowed

6.(b) Name of husband or wife: Thomas C. Swing
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Aug 31, 1863

8. AGE: Years	Months	Days	If less than one day
83	1	29	hrs. ..... min.

9. Birthplace: Phila. Pa.
(Town, county, and state)
10. Usual occupation: At Home
11. Industry or business

FATHER	12. Name	William Eastwick
	13. Birthplace	Phila, Pa
MOTHER	14. Maiden name	Amelia Mansfield
	15. Birthplace	Phila Pa

16. Informant: James S. Eyre.
Address: Swedesboro, N.J.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 1, 1946 (month) (day) (year)
Cemetery or crematory: Bethel
Location: Near Chesapeake City, Md
18. Funeral director: N. W. Lippincott
Address: Elkton, Md
19. Oct 31 1946 (Date rec'd by registrar) H. R. Frazer (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 29 1946, at 2.45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 1945 to Oct 29 1946 and that I last saw h[im] alive on October 29 1946

	DURATION
Immediate cause of death: Acute myocardial failure	Hours
Due to: Chronic Hypertension	
Coronary vascular disease	2 years
Due to:	
Other conditions: Retained Placenta	10 years

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Henry V Dorsey M.D.
M. D. or other
Address: Chesapeake City, Md. Date signed 10-29-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (3rd)

CERTIFICATE OF DEATH

09940

Reg. Dist. No. 91

1. PLACE OF DEATH:

County

City or town: Chesapeake City
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 17 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Cecil

City or town: Chesapeake City
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Harvey L. Williams

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Married

6.(b) Name of husband or wife: Senora G. Williams

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Oct. 26, 1876

8. AGE: Years	Months	Days	If less than one day
70			hrs. min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Retired Farmer

11. Industry or business

FATHER
12. Name: Granger Williams
13. Birthplace: Md.

MOTHER
14. Maiden name: Anna Cookins
15. Birthplace: Md.

16. Informant: Mrs. Senora G. Williams
Address: Chesapeake City, Md.

17. Buried (Burial, cremation, or removal, Which?) Date thereof 11-1-46 (month) (day) (year)

Cemetery or crematory: Bethel Cemetery

Location: Bethel Md.

18. Funeral director: Hilly Cooper

Address: Elkton Md.

19. November 1 1946 (Date rec'd by registrar) Nina Ratcliffe D.H. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 29 1946, at 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 1 1945 to Oct 29 1946 and that I last saw h... alive on October 29 1946

Immediate cause of death	DURATION
Acute myocardial failure	10 min.
Due to: Chronic myocarditis	2 Years
Due to: Nephritis	
Other conditions	

(include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: H. N. Davis M.D.
M. D. or other

Address: Chesapeake City Md. Date signed 10/31/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92)

CERTIFICATE OF DEATH

09941

Reg. Dist. No. 92

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Cecil
City or town: Elkton, Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 79 years
Hospital, Institution, or street address where death occurred: W Main St
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Cecil
City or town: Elkton
(If outside city or town limits, write RURAL and give nearest town)
Street No. 160 W. Main
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Elizabeth W. Hworth

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	Wh	(w)dowed

6.(b) Name of husband or wife: H. Frank Hitworth
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 27, 1867

8. AGE: Years	Months	Days	If less than one day
79	4	24	..... hrs. ..... min.

9. Birthplace: Elkton Md (Town, county, and state)
10. Usual occupation: at Home
11. Industry or business

FATHER
12. Name: William H. Hughes
13. Birthplace: Pa

MOTHER
14. Maiden name: Mary McCleary
15. Birthplace: Maryland

18. Informant: Mrs Emma Hughes Lewis
Address: North St Elkton, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 24 /46 (month) (day) (year)
Cemetery or crematory: Elkton
Location: Elkton, Md

18. Funeral director: H. W. Pippin
Address: Elkton, Md

19. Oct 23 1946 (Date rec'd by registrar) F R Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 21, 1946, at 8:00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1945, to Oct 21 1946
and that I last saw her alive on October 21, 1946

Immediate cause of death: acute myocardial failure — DURATION: 10-21
Due to:
Due to:
Other conditions:
(Includo pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should he charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Dr. Lord W. Shreeve, M.D.
M. D. or other
Address: Elkton, Md Date signed Oct 23